State of Delaware Flexible Spending Account Plan

Summary Plan Description

Inside:

Administered By

ASI
Columbia, MO
800-659-3035

P.O. Box 6044
Columbia, MO 65205-6044

on the web at
http://www.asiflex.com/

NOTE: USE YOUR 6 DIGIT STATE OF DELAWARE EMPLOYEE ID PLUS THE LAST FOUR NUMBERS OF YOUR SOCIAL SECURITY NUMBER TO ENROLL AT OPEN ENROLLMENT, TO FILE CLAIMS AND TO ACCESS YOUR ACCOUNT FROM INFOLINE 125.

INTRODUCTION

A Flexible Spending Account (FSA) is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes.

FSA accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes. FSA participation will impact earnings reported to the Social Security Administration. In accordance with Internal Revenue Code Section 125, allowable premiums for health and dental insurance are currently taken on a pre-tax basis. The more money you put in, the more tax you avoid. When you use the money in your account to pay for out-of-pocket family care expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you will probably save 1/3 or more on out-of-pocket family care expenses.

How does the FSA work?

When you enroll in the FSA plan, you estimate the amount of family care expenses you are sure you will incur during the year. You have that amount deducted from your paychecks in equal amounts throughout the year. Though your actual salary remains the same, your taxable salary as reported to the government is reduced by the amount you put into your FSA.

After you enroll in a FSA, ASI will send you a confirmation of your enrollment and reimbursement forms to your home address. As you incur eligible expenses throughout the year, you submit a Reimbursement Form (by fax or mail) along with documentation of the expense, and you are reimbursed with funds from your FSA account, avoiding taxes. After each claim, you will receive an account summary.

Of course, only costs of purchases made or services provided during the plan year and while you are a participant are eligible for reimbursement. And the IRS rule says that if you don't use all of the money in the account when the plan year is up, those funds will no longer be available to you.

You can only change your election during the plan year as a result of certain eligible event changes. Also, your Social Security benefits calculations will be based on your lower taxable earnings figures. (You can check with your local Social Security office to explore any effects this may have on your benefits – which are usually very minor.)

The State of Delaware has hired ASI to perform certain administrative functions for the Plan. ASI processes all claims for the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. If you have any questions concerning claims, please contact ASI, P. O. Box 6044, Columbia, MO 65205, 800-659-3035, email: asi@asiflex.com, or on-line at www.asiflex.com.

ESTABLISHING AND USING YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Estimate your family's annual out-of-pocket medical expenses. You may include expenses for anyone who is a qualified dependent for tax purposes. (There are exceptions for the expenses of children of divorced parents. Please call ASI at 1-800-659-3035 for further information.) When calculating your annual election, include predictable expenses only.

Annual Maximum $3,000.00 **Annual Minimum $50.00**

Qualifying Medical Expenses include all medical, dental and vision expenses not covered or not reimbursed by insurance which are **incurred by you or your eligible dependent (definition available at www.asiflex.com) during the plan year** for medical care as defined in Section 213(d) of the Internal Revenue Code. Please refer to the following list and IRS Publication 502 (available at www.asiflex.com) for further details on qualifying expenses. **Expenses qualify for the medical FSA based on when incurred, not when they are paid. Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.** Please contact ASI at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

Below is a **partial** listing of qualified expenses. Expenses can only be claimed based on the date incurred regardless of the date you are billed or pay for the expense.

Deductibles
Co-pays
Doctor's fees
Dental expenses
Vision care expenses
Prescription glasses
Contact lenses and solutions
Corrective eye surgery
Prescription drugs
Chiropractor's fees
Medical equipment
Over-the-Counter drugs & medicines (legal) used to treat a medical condition (For specifics, go to http://www.asiflex.com/otc.htm)
Insulin
Orthodontia/braces (See details on page 4)
Routine physicals
Hearing aids including batteries
Transportation expenses related to illness

Non-Qualifying Medical Expenses
This is a **partial** list of medical related items that **do not** qualify under the Plan. There may be other items that do not qualify that are not listed here.

Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
Clip-on or non-prescription sunglasses
Warranties
Toiletries
Long-term care expenses
Medicines, drugs, herbs, or vitamins for general health and not used to treat a medical condition
Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
Health club dues
Any sort of insurance premium

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. You may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. Claims for the entire fee paid at the beginning of treatment will not be processed, nor will claims for an entire year's payments made at the beginning of the year be processed. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed. If you have questions about qualifying orthodontic expenses, please contact ASI at 1-800-659-3035 prior to enrollment in the plan.

Enroll in the Health Care Flexible Spending Account Plan. During open enrollment, divide your annual election by 26, the number of paychecks during the Plan Year. See the separate open enrollment checklist for detailed open enrollment instructions. Enroll on-line during open enrollment. New employees should contact their Human Resources office for an enrollment form and assistance with enrollment.

Receive medical services. A medical expense is **incurred** when the services are provided that create the expense. You must receive medical services before you file a claim for those services.

File claims. After you have received the medical services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASI. See **Flexible Spending Account Claims** on page 12 for details on claims filing. Extra claim forms are available over the Internet at www.asiflex.com or www.delawarepersonnel.com/benefits or from your Human Resources office.

Receive reimbursements. ASI will review your claim, and if approved will reimburse you for the medical expenses within one day of their receipt of the claim.

Payment from your Health Care Flexible Spending Account will be made up to the approved amount of your claim or your remaining annual election, whichever is less. Payment is not limited to the amount in your account at the time of your claim. Your per pay contributions will continue for the remainder of the Plan year.

Participants on unpaid leave. To maintain coverage, you must make arrangements prior to going on unpaid leave with your Human Resources office to pay for coverage after you return from unpaid leave. If a participant has been on unpaid leave for longer than 30 consecutive days and did not elect to catch up contributions when they return, the election and corresponding coverage will be revoked (effective on the last day worked). A new election may be made upon 31 days of return to work, effective for coverage the first of the month following approval of the submitted form. However, no coverage will exist for months in which no contributions were made if the participant had not elected to catch up contributions prior to the end of the 30 days. There will be a hold put on a participant's account (no claims will be paid) if contributions are not received on

two consecutive payrolls and no leave form has been filed with the Human Resources office. **Claims must be filed within 90 days of end of coverage.**

Other Considerations Regarding the Health Care Flexible Spending Account Coverage Continuation (COBRA). To the extent required by COBRA, a participant or his/her spouse or dependent may elect to continue the coverage elected under the Health Care Flexible Spending Account Plan even though the participant's or his/her spouse's or dependent's election to receive benefits expired or was terminated, under the following circumstances:

1) Death of the participant;
2) Termination (other than for gross misconduct) or a reduction in hours;
3) Divorce of the participant;
4) A dependent child ceases to be a dependent under the terms of this plan.

When the Plan is notified that one of the events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by the Administrator. It is the responsibility of the participant or a responsible family member to inform their Human Resources office of the occurrence of an event described in 3 or 4 above.

Continuation coverage will not extend beyond the end of the current Plan Year but may terminate earlier if the premiums are not paid within 30 days of their due dates. **Payments for expenses incurred during any period of continuation shall not be made until the contributions for that period are received by the Administrator.** An administrative charge of 2% is assessed for each premium paid for continuation coverage.

ESTABLISHING AND USING YOUR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Estimate your total dependent care expenses for the Plan Year. Include predictable expenses only.

Annual (household) Maximum $5,000.00 **Annual Minimum $50.00**

You and your spouse together may include up to $5,000.00 per year ($2,500 in the case of a married individual filing a separate tax return for the plan year) or the lesser of your (after subtracting all FSA deductions) or your spouse's earned income for the plan year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of $250 per month if you have one dependent and $500 per month if you have two or more dependents.

A Qualifying Individual is your Dependent who is under the age of 13 (when services are incurred) or your Spouse or an older Dependent who is mentally or physically incapable of self-care who lives in your home at least 8 hours each day. If you are divorced, the Qualifying Individual must be your son or daughter for whom you have more than 50% physical custody. Please call ASI before enrolling in this account if you have unique day care or joint custody arrangements. Be sure to notify your Human Resources office within 31 days of a change in eligibility of a qualifying individual if you need to change your election.

A Qualified Provider can provide care in your home or outside your home. If the care is provided outside your home and the facility cares for more than 5 individuals, then it must be licensed by the State. The expenses **may not** be paid to your spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

The Dependent Care Flexible Spending Account is an alternative to taking a "Tax Credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the "FSA". The IRS will not allow you to receive two tax breaks on the same expenses.

- A **Tax Credit** is allowed for child/dependent care expenses of up to $6,000 per year for two or more dependents ($3,000 per year for one dependent). You file for the "tax credit" on your annual tax return, at the end of the year. The credit is an amount equal to your dependent care expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as your income increases.
- The **Dependent Care Flexible Spending Account** Plan allows a tax break on up to $5,000.00 per year, $2,500 if married filing separately, for any number of dependents; one, two, or more. You will experience "tax savings" throughout the year with every paycheck you receive. Employees who pay federal taxes of 15%, state taxes of approximately 6% and Social Security taxes of 7.65% would save around 28% of expenses through the Dependent Care Flexible Spending Account Plan. As their federal tax percentage rises, they would receive an even higher tax break by using the Dependent Care Flexible Spending Account Plan.

Generally those employees with a combined family income over $31,000 will have a higher percentage tax break through the Dependent Care Flexible Spending Account Plan. Those employees with a combined income under $31,000 generally will have a higher percentage tax break using the Tax Credit. **Please contact your tax advisor if you have questions about which is better for you.**

You are required to file Schedule 2 with your IRS Form 1040A or **Form 2441** with your IRS Form 1040 to support the amount redirected for the calendar year. This is for informational purposes. You will not pay taxes on the redirected amount. Payments made to you under this category are not taxable, but the amount redirected will appear on your W-2 form which informs the IRS that you have received a tax break on that expense.

Qualifying Dependent Care Expenses

Qualifying Child/dependent care expenses are those that you incur in order for you and your spouse (if married) to be gainfully employed that are considered to be employment-related expenses under Internal Revenue Code §21(b)(2) to the extent that you or another person (if any) incurring the expense is not reimbursed for the expense through any other Plan. Only expenses incurred for care and well-being qualify for this tax break (Kindergarten, education related sports camps, summer school and private school expenses, food and transportation do not). Day camp fees incurred in order for you to work are allowable but overnight camps are not. Refer to IRS Publication 503 (available at www.asiflex.com) for additional information. The purpose of Publication 503 is to assist people with their income tax filing. It does not address Dependent Care Flexible Spending Account Plans. However, most of the items listed as eligible for the tax credit in 503 can be claimed through your Dependent Care Flexible Spending Account. You **can only claim expenses based on the date incurred (not paid as stated in 503)**. Please contact ASI at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses.

Qualifying Expenses are those that enable you to be gainfully employed including:

Day-care centers	Babysitters
Day camps	Nannies

Non-Qualifying Dependent Care Expenses

This is a **partial** list of items that **do not** qualify under the plan. There may be other items that do not qualify that are not listed here.

Care that is not incurred in order for you to work or look for work	Care for a child for whom you have 50% or less physical custody
Kindergarten or other educational expenses	Overnight camps
Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school	Care for a child age 13 or older who is not disabled
	Child support payments

Food, transportation or activity fees

Amounts paid to your spouse or dependent or to your (or your spouse's) son or daughter who is under 19 years old at the end of the year

Enroll in the Dependent Care Flexible Spending Account Plan. During open enrollment, divide your estimate by 26, the number of paychecks during the Plan Year. See the separate open enrollment checklist for detailed open enrollment instructions. Enroll on-line during open enrollment. New employees should contact their Human Resources office for an enrollment form and assistance with enrollment.

Receive dependent care services. Dependent care expenses are **incurred** when the day care is provided. You must receive the dependent care services before you file a claim for those services.

File claims. After you have received the dependent care services, you may submit a claim for those expenses to ASI. See **Flexible Spending Account Claims** on page 12 for details on claims filing. Extra claim forms are available by contacting ASI or over the Internet at www.asiflex.com or www.delawarepersonnel.com/benefits.

You may have the dependent care provider complete the dependent care section of the claim form and sign on the line provided in lieu of providing separate documentation for dependent care claims (see page 12).

The tax identification number or Social Security number of the child/dependent care provider should be listed on each of your claim forms. You must provide this number with your federal income tax return. Please check with your childcare provider (**before** enrolling in this category) to be sure that you are able to obtain their tax I.D. number or his/her Social Security number.

Receive reimbursements. ASI will review your claim, and if approved will reimburse you within one business day of their receipt of your claim up to the amount you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from payroll.

Payment from your Dependent Care Flexible Spending Account will be made up to the approved amount of your claim or your current balance, whichever is less. Any portion of your claim which is not paid will be paid automatically as money is contributed from payroll. Total payments for the year are restricted to your annual election.

ENROLLMENT AND TERMINATION

Eligibility: All permanent part-time and full-time employees are eligible to participate in this Plan on the 1st of the month after completing an initial waiting period of 90 days counting his or her Employment Commencement Date as the first such day.

The Plan Year is the twelve-month period from January 1 through December 31 of the same calendar year.

Open enrollment is normally held shortly before the beginning of the Plan Year. Check with your Human Resources office for the exact dates. You may enroll during open enrollment each year for the upcoming Plan Year by enrolling on-line during open enrollment. (You may either select an annual amount or a per check amount and the system will compute the rest for you.) You may also enroll during the plan year if you experience a qualifying change in status and enrollment corresponds with a change in eligibility caused by that status change. See the **Making a Change Section** for more information. The Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan have slightly different rules regarding making an election change or enrolling mid-year. Forms are available from your Human Resources office or online at www.delawarepersonnel.com/benefits.

New employees must enroll by the 1st of the month after completing the initial waiting period of 90 days to participate for the remainder of that plan year. You enroll by completing an enrollment form available from your Human Resources office or online at www.delawarepersonnel.com/benefits. Enrollment forms should be sent by the first of the month preceding the date of eligibilty to ensure timely enrollment. If you fail to enroll within the time period described above, then you may not elect to participate in the Plan until the next Open Enrollment Period or until an event occurs that would justify a mid-year election change.

Enrollment during the plan year is effective the 1st of the month following the initial waiting period.

Termination of participation: Your participation will end on your last day of work should you terminate employment with the State of Delaware. This means you will no longer be able to make contributions to the plan. Should you return to work within 30 days during the same Plan Year, your participation will be reinstated as it was. You will have the option of reinstating your coverage at the same annual level you had prior to your termination or reinstating your coverage at the same per pay period amount with a reduced annual amount. Should you choose the same annual amount, your per pay period contributions will be adjusted so that your total contributions for the year will equal your annual coverage amount. You have 31 days after you return to work during the same Plan Year to make a new election for the remainder of the Plan Year (not to exceed the annual plan maximum). Except as specifed in the section on Coverage Continuation (COBRA) in the Health Care Flexible Spending Account Plan Summary, expenses incurred while you are not a participant will not qualify for reimbursement. You may continue to file for Dependent Care expenses incurred during the Plan Year after the end of your participation. **Claims must be filed within 90 days of end of coverage.**

MAKING A CHANGE

Except as specified in this section, your election under the Plan is irrevocable for the Plan Year. It is the employee's responsibility to file a change with their agency's Human Resources office. The election change request must be filed within 31 days of the date of the qualifying event and becomes effective on the 1st of the month following the event and the approval of the request. Requests received after 31 days will not be approved.

You may change your election if you, your spouse, or a dependent experience an event listed below which results in a gain or loss of eligibility for coverage under the State of Delaware Flexible Spending Account Plan, Health Care Flexible Spending Account Plan, or Dependent Care Flexible Spending Account Plan or a similar plan maintained by your spouse's employer or one of your dependent's employer and your desired election change corresponds with that gain or loss of coverage. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account. Otherwise, your election is effective through the end of the plan year.

Events 1 - 3 apply to the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan.

1. Your legal marital status changes through marriage, divorce, death or annulment.

2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but not under any of the other plans.

3. You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) that affects eligibility for health insurance, the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account with the State of Delaware or a plan maintained by your spouse's or any dependent's employer. Please see page 9 for specifics related to termination of employment from the State of Delaware.

Events 4 - 6 apply to Health Care Flexible Spending Account Plan, but not the Dependent Care Flexible Spending Account Plan.

4. You are served with a judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent. If the order requires you to pay for medical expenses not paid by insurance for a Dependent child, then you may add or increase coverage under the Health Care Flexible Spending Account Plan. If the order requires that another person pay for medical expenses not paid by insurance for the Dependent child, then you may drop or reduce coverage under the Health Care Flexible

Spending Account Plan.

5. If you, your spouse or a dependent becomes entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage under the Health Care Flexible Spending Account Plan.

6. If you, your spouse or a dependent loses eligibility and coverage under Medicare or Medicaid, you may add or increase coverage under the Health Care Flexible Spending Account Plan.

Events 7 - 9 apply only to the Dependent Care Flexible Spending Account Plan.

7. You may change your election to correspond with a change made under another employer-sponsored plan as long as the change made under the other plan was permitted by IRS regulations or was made for a period of coverage that is different from the State of Delaware Flexible Benefit Plan.

8. You change dependent care providers (including school or other free provider). You may make a corresponding change to your Dependent Care Flexible Spending Account and your future salary reductions if you change dependent care providers.

9. You may make a corresponding change to your Dependent Care Flexible Spending Account and your future salary reductions if your dependent care provider who is not your relative changes your costs significantly. A relative is any person who is a relative according to Code §152(a)(1) through (8), incorporating the rules of Code §152(b)(1) and (2).

Your Salary Reduction amount for a pay period is, an amount equal to the annual contribution for your FSA election, divided by the number of pay periods in the Plan Year following your effective date. If you increase an election under the Health Care Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan, your salary reductions per pay period will be an amount equal to your new reimbursement limit elected less the salary reductions made prior to such election change, divided by the number of pay periods remaining in the Plan Year beginning with the election change effective date.

Any increase in your election may include only those expenses that are incurred during the period of coverage on or after the effective date of the increase. Your coverage for the remaining period of the year shall be calculated by adding the amount of contributions made prior to the change to the expected contributions after the effective date of the change and subtracting prior reimbursements.

FLEXIBLE SPENDING ACCOUNT CLAIMS

- Claims processed daily – within 1 day of receipt of qualified claim
- Fax or mail to ASI:
  1-573-874-0425
  P O Box 6044
  Columbia, MO 65205-6044
- World Wide Web www.asiflex.com for claim forms and personal account information
- Direct deposit is available for claims payment
- Direct deposit notices sent via E-mail or US Mail the same day payment is generated
- InfoLine 125:
  1-800-366-4827
  24 hour/day, 7 days/week
  automated balance information

Allowable expenses must be incurred during the portion of the Plan Year that you are a participant. Claims must be filed by March 31st following the end of the Plan Year. (Employees who have terminated employment during the year must file claims for expenses incurred while covered under the plan within 90 days of termination from a benefit eligible position.) After that, your account will be closed and any balance remaining will be forfeited to the State of Delaware in accordance with federal regulations. If March 31st is a holiday, Saturday, or Sunday, then claims must be filed by the first business day following March 31st.

You must submit a completed claim form along with **copies** of invoices or statements **from the provider** to serve as proof that you have incurred an allowable expense in order to receive payment. Statements are **required** to **include,** the **provider's name**, the **date(s) of service,** a **description of the service(s),** and the expense **amount.** Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation or copies will not be returned. For over-the-counter items, the receipt or documentation from the store must include the name of the drug pre-printed on the receipt. You must indicate the existing or imminent medical condition (items such as vitamins and nutritional supplements may require a physician's statement) for which the item will be used on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available by contacting ASI or over the Internet at www.asiflex.com or www.delawarepersonnel.com/benefits.

Purchases for general good health will not be accepted. Claims for items that are purchased for an existing medical condition must be accompanied by a letter from your doctor stating the medical condition and the items that are required as treatment for that specific medical condition (if they would otherwise not qualify as a general good health item). A sample letter is available at www.asiflex.com. This letter can be used as support for 12 months from the date of the letter.

Direct deposit into the bank account of your choice is available for your claim payments. By using direct deposit you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by **email** over the Internet. If you prefer, a check can be mailed to you instead of payment by direct deposit.

INTERNET ACCESS

You can access your Health Care Flexible Spending Account and your Dependent Care Flexible Spending Account on the Internet 24 hours/day, 7 days/week. Information is updated every morning to reflect the previous day's transactions. Find out if a claim has been processed, a payment has been made or your current balance. Information for the current Plan Year is available (previous Plan Year as well until March 31st following the end of that Plan Year). There is no personally identifying information on the Internet. Which means this information will be meaningful to you, but not to anyone else.

1. Go to http://www.asiflex.com
2. Click on "**Account Detail**"
3. Click in the box to the right of "**Your FlexPin**"
4. Type your Personal Identification Number (P.I.N). Your PIN is provided on your enrollment confirmation. You can also call ASI at (800) 659-3035 to get your PIN.
5. Click "**Submit**"
6. Select the Plan Year from the drop down box if available. This box will not be displayed if only one Plan Year is available.
7. Select the category you wish to view if you are enrolled in more than one category. All transactions for the Plan Year are shown through the previous day. Information is updated early each morning.
8. Click "**Lookup**"
9. Be sure to click "**Sign out (or enter another FlexPin**)" when you finish. This closes out your account for security purposes.

Sample Claim and Provider Documentation

This day care receipt contains the items the Internal Revenue Code requires:

1. It is signed by the provider of service - "Ima Sitter"
2. It contains a description of the services - "day care services"
3. It explicitly lists "1-2-04 to 1-08-04" as the range of the dates that the day care was provided.
4. It includes the amount charged for the day care "$300.00"; not necessarily the amount paid.
5. It identifies the person for whom the day care was provided - "Mike Riddick"

Day care documentation must contain all of these items in order to be processed.

I provided day care services for Mike Riddick

From 1/02/04 to 1/08/04. The total sum for services provided was $300.00.

Signed Ima Sitter

Ima Sitter
123 Main Street
Columbia, MO 65203
SSN 123-45-6789

We must be able to identify the participant

ASI

CLAIM FORM

Please read requirements on reverse side

Riddick, John M.	ASI	111 — 22 — 4444
Last Name, First Name	Employer	Social Security Number
110 E. Ash St.		Columbia MO 65203
Street Address		City,State,Zip

Dependent Care Assistance (day care, babysitting, etc.)

Name of Dependent	Age	Service Period From	Service Period To	Name, Address and Tax Payer Id number of Provider of service	Charge for Services	ASI use only
Mike	10	1/02	1/08	Ima Sitter, 123 Main St. Columbia MO 65203 123-45-6789	300.00	
				Total Dependent Day Care Claim →	300.00	

I provided the dependent care as stated above

Care Provider's original signature | Date | SSAN/Tax ID#

Medical Benefits

Date Care Provided*	Name of Service Provider	Expense Description	Name and relationship of Person for whom expense incurred	Amount that is your responsibility	ASI use only
01/05/04	I William See, M.D.	Eye Exam	Mary - daughter	10.00	
			Total Medical Amount Requested →	10.00	

Please arrange documentation in order listed above.

*Claims for future services will not be accepted.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

John M. Riddick — Employee Signature

01/08/04 — Date

The participant must sign the claim form.

Every request and all documentation must contain all the items shown in blue

Separate dependent care documentation is not required if the provider signs the form after the dependent care section is completed.

I. William See, MD
Ophthalmology
2020 Seymour
Crystalview, MO 65201

Service Date	Description	Charge for Services
01/05/04	Eye Exam	$10.00

Patient's Name Mary Riddick

This health care service statement contains the items the Internal Revenue Code requires:

1. It identifies the provider of service - "I. William See, MD"
2. It contains a description of the services - "Eye Exam"
3. It explicitly states the date of the eye exam - "1/05/04"
4. It includes the amount charged for the exam "$10.00"; not necessarily the amount paid at the time of service.
5. It identifies the person receiving the eye exam - "Mary Riddick"

Medical documentation must contain all of these items in order to be processed.